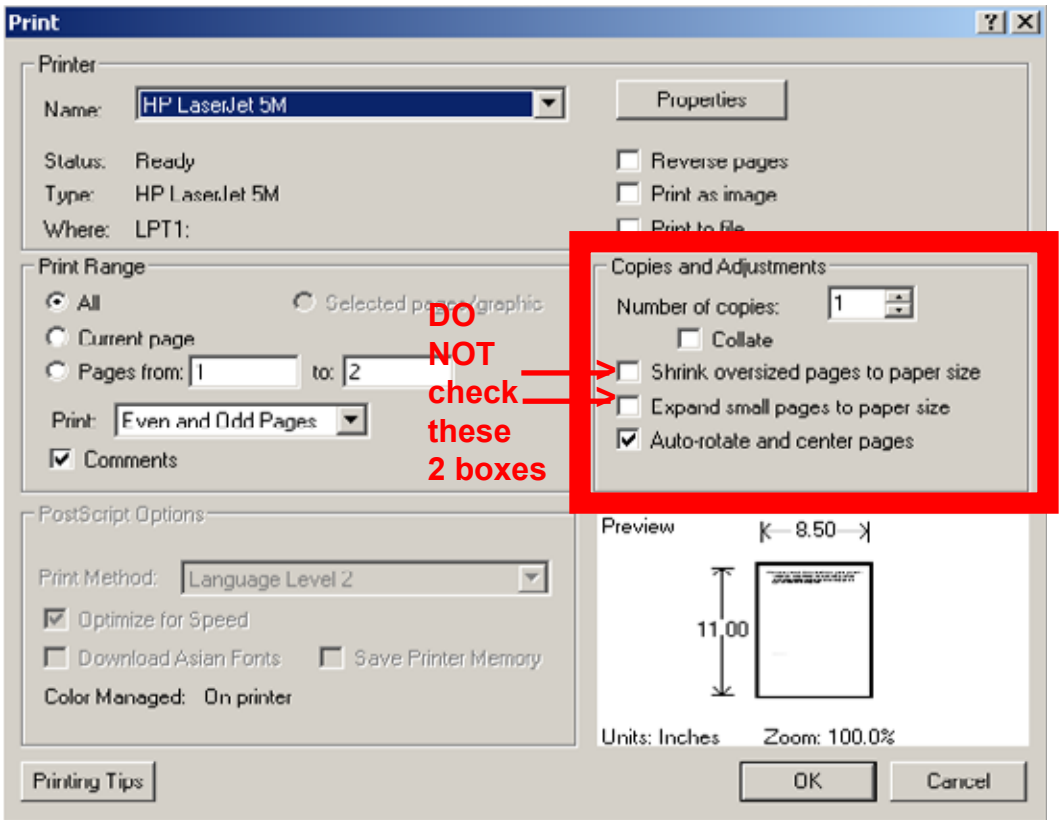
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



DOH 600-033 (6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Prosthetist Licensure Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Prosthetist

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 677-017 (REV 6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application Instructions For Prosthetist Licensure

Requirements for licensure

To qualify for credentialing in Washington, an applicant must:

(a) Possess a bachelor degree in prosthetics from an approved prosthetic education program. Alternatively, a candidate may complete a certificate program in prosthetics from an approved education program;

(b) Complete a clinical internship or residency of 1900 hours;

(c) Complete an examination.

Application Requirements

(1) A completed application on forms provided by the Secretary;

(2) Official transcripts, certificate, or other documentation forwarded directly from the issuing agency where the applicant has earned a bachelor degree or completed a certificate program from an NCOPE or CAAHEP accredited program;

(3) Documentation of completion of an internship or residency of at least 1900 hours; (Form provided.) Applicants who have completed a residency which is approved by the National Commission on Orthotic and Prosthetic Education (NCOPE) or Commission for Accreditation of Allied Health Education Programs (CAAHEP) must provide a certificate of completion, a letter from the direct supervisor, or other documentation directly from the residency program.

(4) Documentation of successful completion of the American Board For Certification In Orthotics And Prosthetics (ABC) written multiple choice and patient simulation examinations for each discipline in which you are applying for a credential and must have been completed after July 1, 1991. Applicants who wish to be referred to ABC by the Department of Health, must submit all application requirements to the Department at least 180 days prior to the examination.

(5) One (1) passport size photographs taken within one year of application. Sign and date the photo **across** the bottom and attach to the application;

(6) Verification of credential status from all states and Provinces where applicant has been issued a credential to practice orthotics or prosthetics—whether active or inactive, indicating that the applicant is or has not been subject to charges or disciplinary action for unprofessional conduct or impairment (Form provided may be duplicated.);

(7) Two (2) professional references requests from employers and at least one physician from whom the applicant has received referrals (Forms provided.);

(8) Four hours of AIDS education as required in Chapter 246-12 WAC, Part 8.

(9) Prosthetist fee of $250.00. Please make checks payable to Department of Health and mail with the application to **PO Box 1099, Olympia, WA 98507-1099. (All fees are non-refundable.)**

(10) Required documentation for affirmative responses to personal data questions.

(11) Additional information as required by the secretary.

Applications will be acknowledged and deficiencies noted.

Applications will **not** be considered complete until all required supporting documents are on file with the Secretary of Department of Health.

Applications for credentialing without examination will be reviewed by the Secretary of Department of Health or its Designee.

Supporting documents, or correspondence should be sent to:

Department of Health
Orthotics and Prosthetics Program
PO Box 47870
Olympia, WA 98504-7870

If you have any questions, please contact Program Staff at 360-236-4948.

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE #	ISSUANCE DATE

LICENSE #

Application for Prosthetist Licensure

Please Type or Print Clearly—Carefully follow all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change.

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list full name(s)

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Previous Licensure

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. (Attach additional 8 1/2 x 11 sheets if necessary.)

STATE OR OTHER JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE	ACTIVE	INACTIVE
			YEAR ISSUED	NUMBER			

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 x 11 sheets if necessary.)

SCHOOLS ATTENDED FULL NAME, CITY AND STATE	DEGREE EARNED	ATTENDANCE	
		FROM (MO/DA/YR)	TO (MO/DA/YR)

5. Professional Experience

In chronological order, list all professional experience. (Exclude activities listed under other sections.)
(Attach additional 8 1/2 x 11 sheets if necessary.)

PRACTICE/LOCATION	NAME OF SUPERVISOR	TOTAL HOURS PER WEEK	INCLUSIVE DATES OF EXPERIENCE	
			FROM (MO/DA/YR)	TO (MO/DA/YR)

6. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state and federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Orthotics and Prosthetics Program
P.O. Box 47870
Olympia, WA 98504-7870

Verification of Licensure

APPLICANT'S NAME (PLEASE PRINT)	DATE OF BIRTH (MONTH/DAY/YEAR)

I have applied for a license to practice ☐ Orthotics ☐ Prosthetics in the state of Washington. Before my license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state licensure and return it directly to:

Department of Health
Orthotics and Prosthetics Program
PO Box 47870
Olympia, WA 98504-7870

I hereby authorize you to release the following information to the Washington State Department of Health.

Applicant's Signature _____ Date _____

License Number _____ Date License was Issued _____

Status of License: ☐ Active ☐ Inactive ☐ Military ☐ Expired

☐ Other (specify) _____

Has the applicants license ever been suspended or revoked? ☐ Yes ☐ No

Has any other disciplinary or corrective action been taken? ☐ Yes ☐ No

Has the licensee surrendered the license in lieu of disciplinary action? ☐ Yes ☐ No

If you have answered Yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.

State Board _____

State Seal

Address _____

_____

Telephone _____

Signature _____ Date _____

Print Name _____ Title _____

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Washington State Department of Health
Orthotics and Prosthetics Program
P.O. Box 47870
Olympia, WA 98504-7870

Professional Reference Request

Upon completion of form please mail directly to the Department of Health, Orthotics and Prosthetics Program, PO Box 47870, Olympia, Washington 98504-7870. NOTE: Please be advised that upon receipt of written request, this form may be released to the applicant. However addresses and telephone numbers will not be released. This form may be duplicated.

_____ has applied for licensure as an
NAME OF APPLICANT

☐ Orthotist ☐ Prosthetist in the State of Washington and has given your name as a reference.

Your Name _____ Telephone _____

Organization _____ Position _____

Address _____

City _____ State _____ Zip _____

I. Relationship to Candidate: ☐ Supervisor ☐ Professional Colleague ☐ Other (specify) _____

Approximate date of this relationship: From _____ To _____

Applicant's time spent in ☐ Orthotics ☐ Prosthetics practice:

Applicant's position and name of organization _____

II. Describe briefly the applicant's duties as you know them in the position listed above:

III. Please comment on the applicant's professional judgment, responsibility, integrity, and relations with professional peers and with clients. _____

IV. Do you have any concerns in recommending this applicant for licensure in the state of Washington? If yes, please comment specifically. Include any other information you consider relevant. _____

V. Is there any other information about this applicant which you believe should be provided to the Department of Health? If so, please explain _____

To the best of my knowledge I have answered the above questions truthfully.

Signature _____ Date _____

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Washington State Department of Health
Orthotics and Prosthetics Program
P.O. Box 47870
Olympia, WA 98504-7870

Internship Training

Applicants must complete an internship of at least 1900 hours in each area for which a license is sought. Individual internships must be completed within a minimum period of one year. The internship must be completed under a supervisor qualified by training and experience in an established facility and in corporate patient management and clinical experience in rehabilitation, acute and chronic care in pediatrics and of adults.

Note: If you have completed a 1900 hour internship or residency program which is approved by the National Commission on Orthotic and Prosthetic Education (NCOPE) or the Commission for Accreditation of Allied Health Education Programs (CAAHEP) **you should submit, in lieu of this form,** a certificate of completion or other documentation directly from the NCOPE or CAAHEP approved program.

APPLICANT'S NAME:	TYPE OF INTERNSHIP: ☐ Orthotic ☐ Prosthetic

Dates of Internship		NAME OF SUPERVISOR (Please Print or Type):
Beginning Date	Ending Date	QUALIFICATIONS OF SUPERVISOR:
LOCATION AND ADDRESS:		
DESCRIPTION OF SUPERVISED WORK ACTIVITIES AND NATURE AND EXTENT OF SUPERVISION:		
SIGNATURE OF SUPERVISOR:		

Dates of Internship		NAME OF SUPERVISOR (Please Print or Type):
Beginning Date	Ending Date	QUALIFICATIONS OF SUPERVISOR:
LOCATION AND ADDRESS:		
DESCRIPTION OF SUPERVISED WORK ACTIVITIES AND NATURE AND EXTENT OF SUPERVISION:		
SIGNATURE OF SUPERVISOR:		

Dates of Internship		NAME OF SUPERVISOR (Please Print or Type):
Beginning Date	Ending Date	QUALIFICATIONS OF SUPERVISOR:
LOCATION AND ADDRESS:		
DESCRIPTION OF SUPERVISED WORK ACTIVITIES AND NATURE AND EXTENT OF SUPERVISION:		
SIGNATURE OF SUPERVISOR:		

This form may be duplicated

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Washington State Department of Health
Orthotics and Prosthetics Program
P.O. Box 47870
Olympia, WA 98504-7870

Verification of the American Board for Certification in Orthotics and Prosthetics, Inc. Examination

Applicant Name: _____

Please indicate the date the above applicant ***successfully completed*** the following examinations (not the date certified by ABC):

Orthotic Written Multiple Choice _____

Orthotic Written Simulation _____

Prosthetic Written Multiple Choice _____

Prosthetic Written Simulation _____

Signature _____ Date _____

Return this form to: Department of Health
Orthotic and Prosthetic Program
PO Box 47870
Olympia, WA 98504-7870

(360) 586-4359 FAX

If you have any questions regarding the completion of this form, please contact our office at (360) 236-4948.

Note To The Applicant:

Please forward this form to the: American Board for Certification in Orthotics and Prosthetics, Inc.
330 John Carlyle St., Suite 210
Alexandria, VA 22314

Official Seal